STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBERT E LEE	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/29/15 Facility Number: 001145 Provider Number: 155616 AIM Number: 200120200 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Robert E Lee was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke	K010000	PREPARATION AND/ OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/ or executed in compliance with state and federal laws. The facility is requesting a Desk Review of compliance for this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	detectors hard wired to the nurses call system in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 69 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 02/04/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 12 hazardous	K010029	1.No residents were found to be affected. A self closing device was installed on the Hall 123	02/20/2015

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	areas such as fuel fired heater rooms were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Hall 23 Dining Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, one natural fired furnace was installed in the Hall 23 Dining Room closet which had two entry doors one of which latched into the frame at the top of the door. The second door in the door set was not provided with a self closing device. Based on interview at the time of observation, the Maintenance Director acknowledged the door set to the aforementioned hazardous area was not provided with a self closing device. 3.1-19(b)		Dining Room Furnace Closet door on 2/11/15. 2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in-serviced on 2/11/15 on the requirements of K 029. A %100 facility audit was completed 2/5/15 to identify any other hazardous areas such as fuel fired heater rooms were separated from other areas by self closing doors; no other areas were found tobe out of compliance. A self closing device was installed on the Hall 123 Dining Room Furnace Closet door on 2/11/15. 3.The monthly preventative maintenance check list has been updated to include an audit of hazardous areas such as fuel fired heater rooms are separated from other areas by self closing doors. The Maintenance Director or designee will complete the check list monthly and report findings to the Administrator. If any areas of non-compliance are identified an action plan will be developed. The Maintenance Director will be responsible for ensuring that any work completed by vendors, contractors etc. are inspected to comply with K 029. 4.The Maintenance Director/ designee will complete the Environmental Safety QA audit tool weekly x4 and monthly x6 reporting results to the QA committee. The QA committee	

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			will determine need for further review.	
K010046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review, observation and interview; the facility failed to document monthly functional testing of emergency lighting in accordance with LSC 7.9 for all battery powered lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Preventive Maintenance Record" for 2014 and 2015 with the Maintenance Director from 9:45 a.m. to 11:55 a.m. on 01/29/15, documentation of an itemized listing of monthly functional testing for not less than 30 seconds for each battery powered emergency light in the facility within the	K010046	1.No residents were found to be affected. A monthly 30 second functional test was completed on all battery backup emergency lighting on 2/10/15 and results itemized on emergency lighting testing log. 2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on the appropriate testing and itemized documentation of battery backup emergency lighting monthly in accordance with K046. The Administrator or designee will review emergency lighting testing log to ensure itemized timely testing is completed. 30 second functional testing on all emergency lighting completed 2/10/15 and results itemized on emergency lighting testing log, all emergency lights were operational. 3.The monthly preventative maintenance check list was updated to specify monthly itemized log of 30 second emergency lighting battery backup testing. The Maintenance Director/ designee will be responsible for completing the	02/20/2015

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	most recent twelve month period was not available for review. The aforementioned documentation stated "Check all exit lights for proper operation" as the results of monthly functional testing. Based on interview at the time of record review, the Maintenance Director acknowledged an itemized listing of the location and results of monthly functional testing for not less than 30 seconds for the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, a total of 16 battery powered emergency lights were observed installed in the facility and each light operated when its respective test button was pushed. 3.1-19(b)		monthly testing of battery operated emergency lights. The Administrator will review the preventative maintenance book monthly to ensure completion. If non compliance areas are identified anaction plan will be developed. 4.The Maintenance Director will complete the Environmental Safety QA audit tool weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.	
K010048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 1. Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of smoke detectors hard wired to the nurses call system in 75 of 75 resident sleeping rooms. LSC 19.2.2.2 requires a written	K010048	1.No residents were found to be affected. The Disaster Preparedness Manual was updatedto include a written fire safety plan for staff response to the activation of smoke detectors hard wired to the nurses call system in 75 of 75 resident sleeping rooms on 2/10/15. The	02/20/2015

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	health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Preparedness Manual" documentation dated March 2009 with the Maintenance Director from 9:45 a.m. to 11:55 a.m. on 01/29/15, the facility's written fire safety plan did not include staff response to the activation of smoke detectors hard wired to the nurses call system in resident sleeping rooms. Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, smoke detectors hard wired to the nurses call system are installed in all resident sleeping rooms. The smoke detector installed in Room 107 provided a local audible alarm and reported to the nurses call system when		written fire safety plan for the facility was updated to include the use of kitchen fire extinguishers on 2/10/15. All staff education related to the updated Disaster Preparedness Manual as well as the fire safety plan including the use of kitchen fire extinguishers to be completed by 2/20/15 by the Administrator or designee. 2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in-serviced on 2/11/15 on the requirements of K 048. The Disaster Preparedness Manual was updated to include a written fire safety plan for staff response to the activation of smoke detectors hard wired to the nurses call system in 75 of 75 resident sleeping rooms. The written fire safety plan for the facility was updated to include the use of kitchen fire extinguishers. All staff education related to the updated Disaster Preparedness Manual as well as the fire safety plan including the use of kitchen fire extinguishers to be completed by 2/20/15 by the Administrator or designee. 3.The facility Disaster Preparedness Manual will be reviewed monthly to ensure it remains current by the Administrator or designee. The updated Disaster Preparedness and fire safety plan will be added to the new employee orientation. The verification process for	

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	its respective test button was pushed at 2:50 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of resident sleeping room smoke detectors. 3.1-19(a) 2. Based on record review, observation and interview; the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect three kitchen staff. Findings include: Based on review of "Disaster		response to a resident sleeping room smoke detector alarm as well as the use of the kitchen fire extinguisher will be added to the monthly facility fire drill. The Maintenance Director will monitor compliance and any areas of non-compliance that are identified anaction plan will be developed. 4.The Maintenance Director/ designee will complete Disaster Plan and Fire Safety Plan QA audit to verify staff understanding and proper response to the updated facility Disaster Preparedness Manual and fire safety plan; weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.	

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	Preparedness Manual" documentation dated March 2009 with the Maintenance Director from 9:45 a.m. to 11:55 a.m. on 01/29/15, the written fire safety plan did not address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, one K class fire extinguisher was located in the kitchen. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher. 3.1-19(a)			
K010051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull			

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	stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure 1 of 61 smoke detectors installed on a ceiling were located not less than four inches from a sidewall. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.4.3 requires spot-type smoke detectors shall be located on the ceiling not less than four inches (100 mm) from a sidewall to the near edge or, if on a sidewall, between 4 inches and 12 inches (100 mm and 300 mm) down from the ceiling to the top of the detector. This deficient practice could affect 2 residents, staff and visitors in the elevator. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, a smoke detector hard wired to the fire alarm system was installed on the ceiling one inch from a sidewall in the elevator machine room. Based on interview at the time of observation, the	K010051	1.No residents were found to be affected. The elevator machine room smoke detector was moved to more than 4 inches of the wall on 2/6/15. 2.All residents have the potential to be affected by this deficient practice. A %100 audit was completed of the facility to identify any other smoke detectors located less than 4 inches from a side wall on 2/6/15; no others were identified. The Maintenance Director in-serviced on K 051 regarding the need for smoke detectors to be located more than 4 inches of a side wall on 2/11/15. 3.The monthly preventative maintenance check list has been updated to include an audit smoke detectors located less than 4 inches from a side wall. The Maintenance Director or designee will complete the check list monthly and report findings to the Administrator. If any areas of non-compliance are identified an action plan will be developed. The Maintenance Director/ designee will be responsible for ensuring that any work completed	02/20/2015

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	Maintenance Director acknowledged the aforementioned smoke detector was installed on the ceiling less than four inches from a sidewall. 3-1.19(b)		by vendors, contractors etc. are inspected to comply with K 051. 4.The Maintenance Director/ designee will complete the Environmental Safety QA audit tool weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.	
K010052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 1. Based on record review, observation, and interview; the facility failed to document annual functional testing of 75 of 75 single station smoke detectors installed in the facility. NFPA 72, 7-3.3 states single station smoke detectors installed in other than one- and two-family dwelling units shall be tested and maintained in accordance with Chapter 7. Table 7-3.2 requires all single station smoke detectors to be functional tested annually. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice could affect all residents, staff and visitors.	K010052	1.No residents were found to be affected. An annual functional testing was completed on75 of 75 single station smoke detectors installed in the facility on 2/13/15 and testing documented on the facilities annual single station smoke detector testing log. The Maintenance Director identified the circuit for the fire alarm system as well as verified that it is on a dedicated branch circuit on 2/11/15. The fire alarm system circuit breaker was marked in RED, labels were placed on the circuit breaker panel as well as a sign at the fire alarm system indicating the location of the fire alarm system circuit breaker. The smoke detectors for rooms 101, 103, 105,107, 109, 111, and 113	02/20/2015

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	Findings include: Based on record review with the Administrator and the Maintenance Director from 9:45 a.m. to 11:55 a.m. on 01/29/15, documentation of annual testing of resident sleeping room smoke detectors was not available for review. Based on interview at the time of record review, the Maintenance Director stated resident sleeping room smoke detectors are hard wired to the building's electrical system and the facility's nurses call system and do not contain batteries as a secondary power supply. In addition, the Maintenance Director stated resident sleeping room smoke detectors are sensitivity tested biannually as evidenced by SimplexGrinnell's "Smoke Detector Sensitivity Testing" documentation dated 09/12/13. However, the Maintenance Director acknowledged documentation of annual testing of resident sleeping room smoke detectors within the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, each of 75 resident sleeping rooms has a smoke detector installed which is hard wired to the building's electrical system and the facility's nurses call system and do not contain batteries as a secondary power supply. The smoke		were relocated out of direct air flow and more than 3 feet from an air supply diffuser by 2/10/15. 2.All residents have the potential to be affected by the deficient practices. The Maintenance Director was in-serviced on K 052 on 2/11/15. An annual functional testing was completed on 75 of 75 single station smoke detectors installed in the facility on 2/13/15 and testing documented on the facilities annual single station smoke detector testing log; all were found to be fully operational. There is only one fire alarm system in the facility. The Maintenance Director identified the circuit for the fire alarm system as well as verified that it is on a dedicated branch circuit on 2/11/15. The circuit breaker was marked in RED, labels were placed on the fire alarm system circuit breaker panel as well as a sign at the fire alarm system indicating the location of the fire alarm circuit breaker. A % 100 audit of facility smoke detectors was completed to identify other smoke detectors that were located less than 3 feet from an air supply diffuser or return air opening or located in direct air flow; smoke detectors in room 101, 103, and room 111 were identified and relocated out of direct air flow and more than 3 feet from an air supply diffuser by 2/10/15. 3.The annual preventative	

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	detector installed in Room 107 provided a local audible alarm and reported to the nurses call system when its respective test button was pushed at 2:50 p.m. 3.1-19(a) 2. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could		maintenance check list was updated to include annual functional testing of single station smoke detectors. The monthly preventative maintenance checklist was updated to include verification of labeling/ identification of the Fire Alarm System circuit breaker at the Circuit Breaker as well as the Fire Alarm System, and audit of facility smoke detectors to ensure they are located morethan 3 feet from an air supply diffuser or return air opening or located out of direct air flow. The Maintenance Director/ designee will be responsible for completing the annual testing of single station smoke detectors as well as completing annual/ monthly preventative maintenance check lists. The Administrator will review the preventative maintenance book monthly to ensure completion. If non compliance areas are identified anaction plan will be developed. 4.The Maintenance Director will complete the Environmental Safety QA audit tool weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.	

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	affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, the fire alarm system breaker could not be located or identified. Based on interview at the time of observation, the Maintenance Director stated he did not know the location of the fire alarm system breaker in the facility and acknowledged the fire alarm system breaker could not be located or identified. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain 4 of over 75 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 28 residents, staff and visitors. Findings include:			

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	Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, the smoke detector mounted on the ceiling in Room 105, Room 107, Room 109 and Room 113 was located eight inches from a ceiling mounted boiler unit air vent in the room. Based on interview at the time of the observations, the Maintenance Director stated the facility has smoke detectors hard wired to the nurses call system installed in Room 105, Room 107, Room 109 and Room 113, the ceiling mounted boiler units create an airflow at the vents and acknowledged the aforementioned smoke detectors were each located on the ceiling less than three feet from an air vent. 3.1-19(b)			
K010067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary	K010067	1.No residents were found to be affected. The fire damper in the ceiling HVAC supply vent in the kitchen storage room will be inspected and maintenance	02/20/2015

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	maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect three staff and visitors in the kitchen. Findings include: Based on record review with the Maintenance Director from 9:45 a.m. to 11:55 a.m. on 01/29/15, documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, one fire damper was noted in the ceiling HVAC supply vent in the kitchen storage room. No documentation was observed affixed to the fire damper indicating the manufacture date or the		performed by 2/20/15. 2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on K 067 including the requirement of inspection and maintenance of fire dampers every 4 years on 2/11/15. The Administrator or designee will review Fire/Smoke Damper Maintenance Log to ensure completion. A %100 audit of the facility was completed to identify other fire/ smoke dampers requiring testing and maintenance; no others were identified. 3.The annual preventative maintenance check list was updated to specify every 4 year inspection and maintenance of facility fire/smoke dampers. The Maintenance Director/ designee will be responsible for ensuring the every 4 year inspection and maintenance on fire/ smoke dampers is completed. The Administrator will review the preventative maintenance book monthly to ensure completion. If non compliance areas are identified anaction plan will be developed. 4.The Maintenance Director will complete the Environmental Safety QA audit tool weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.	

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	date of the most recent inspection and necessary maintenance. Based on interview at the time of observation, the Maintenance Director acknowledged there was a fire damper installed in the kitchen storage room and documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review. 3.1-19(b)			
K010068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 2 of 2 natural gas fired dryers in the laundry was provided with combustion air taken directly from the outside. This deficient practice could affect two staff and visitors in the laundry. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, each of two natural gas fired	K010068	1.No residents were found to be affected. An outside vent to supply combustion air directly from outside was installed in the laundry room to supply 2 of 2 naturalgas fired dryers in the laundry on 2/4/15. 2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on the requirement of combustion and ventilation air in accordance with K 068 on 2/11/15. A %100 audit was completed on 2/4/15 to identify other areas requiring proper combustion air taken directly from	02/20/2015

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	dryers in the laundry were not provided with combustion air supply taken directly from the outside. Based on interview at the time of observation, the Maintenance Director acknowledged each of two natural gas fired dryers in the laundry were not provided with combustion air supply taken directly from the outside. 3.1-19(b)		outside;no other areas were found to be out of compliance. 3.The annual preventative maintenance check list was updated to include verification of proper combustion and ventilation air for boiler, incinerator and heater rooms. The Maintenance Director will be responsible for ensuring that any work completed by vendors, contractors etc. are inspected to comply with K 068. The Administrator will review the preventative maintenance book monthly to ensure completion. If non compliance areas are identified an action plan will be developed. 4.The Maintenance Director will complete the Environmental Safety QA audit tool weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.	
K010069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 1998 edition, Section 3-2.6 states	K010069	1.No residents were found to be affected. An enclosed metal container for grease to drain into was ordered for the kitchen range hood system drip tray and will be installed by 2/20/15. 2.All residents have the potential to be affected by this deficient practice. The Maintenance Director and Dietary Manager were in-serviced on the requirement the enclosed metal	02/20/2015

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	kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect three staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:15 p.m. on 01/29/15, one of one designated locations underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into. The designated location for a grease container had a one inch in diameter hole in the drip tray beneath the system filters and had an affixed bracket for holding a container but no container was present. Based on interview at the time of observation, the Maintenance Director acknowledged the designated location underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into. 3.1-19(b)		container for grease to drain into to be installed on the range hood system drip tray in accordance with K 069 on 2/11/15. A %100 audit was completed on 2/5/15 to identify other areas affected; none were identified. 3.The monthly preventative maintenance check list was updated to include verification of placement of the container for grease to drain into on the kitchen range hood system. The Maintenance Director or designee will be responsible for ensuring that the container is in place. The Administrator will review the preventative maintenance book monthly to ensure completion. If non compliance areas are identified an action plan will be developed. 4.The Maintenance Director will complete the Environmental Safety QA audit tool weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.	

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K010144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 10 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required	K010144	1.No residents were found to be affected. A monthly 30 minute load test for the facility emergency generator was completed and logged on the monthly generator load test log on 2/13/15. As part of the monthly 30 minute load test for the facility generator completed on 2/13/15 the time for emergency power transfer within 10 seconds was documented on the monthly generator load test log on 2/13/15. 2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on the requirement of monthly 30 minute generator load testing including testing and documentation of the time for emergency power transfer within 10 seconds in accordance with K 144 on 2/11/15. 3.The monthly preventative maintenance check list was updated to include 30 minute emergency generator load testing as well as the testing and documentation of the time for emergency power transfer. The Maintenance Director/ designee	02/20/2015

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	testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Generator System Service & Testing" documentation dated January 2014, "Emergency Generator Preventive Maintenance" for 2014 and Nixon Power Services Company load bank documentation dated 04/23/14 with the Maintenance Director during record review from 9:45 a.m. to 11:55 a.m. on 01/29/15, documentation of monthly load testing for February, March, May, June, July, August, September, October, November, December 2014 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged monthly load testing documentation for the aforementioned ten month period in 2014 was not available for review. 3.1-19(b) 2. Based on record review and interview,		will be responsible for completing 30 minute emergency generator load testing as well as the testing and documentation of the time for emergency power transferwithin 10 seconds. The Administrator will review the preventative maintenance book monthly to ensure completion. If non compliance areas are identified an action plan will be developed. 4.The Maintenance Director will complete the Environmental Safety QA audit tool weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.	

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	the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 1 of 1 emergency generators. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Generator System Service & Testing" documentation dated January 2014, "Emergency Generator Preventive Maintenance" for 2014 and Nixon Power Services Company load bank documentation dated 04/23/14 with the Maintenance Director during record review from 9:45 a.m. to 11:50 a.m. on 01/29/15, documentation for emergency power transfer time for the twelve month period of February 2014 through January 2015 for the emergency generator serving the facility was not available for review.			

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	Based on interview at the time of record review, the Maintenance Director stated no additional emergency power transfer time documentation was available for review and acknowledged emergency power transfer time was not documented for the twelve month period of February 2014 through January 2015 for the emergency generator. 3.1-19(b)			